Cogitare Enfermagem

ORIGINAL ARTICLE

THE CRISIS PHENOMENON IN THE CARE OF PEOPLE WHO USE DRUGS: A PHENOMENOLOGICAL STUDY*

HIGHLIGHTS

1. Understands the crisis phenomenon related to people who use drugs.
2. It strengthens mental health care in a psychosocial way.
3. It contributes to the work of workers in the psychosocial context.
4. Identify the expectations of workers in crisis care.

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ABSTRACT

Objective: To understand the meaning of the crisis phenomenon and the motivations and expectations of workers in the care of people in crisis in a Psychosocial Care Center for Alcohol and Drugs (CAPSad). **Method:** qualitative research, based on Alfred Schutz's social phenomenology, was carried out with 14 workers in January and February 2022 in the municipality of Porto Alegre, RS, Brazil. The interviews were subjected to phenomenological analysis. **Results:** the crisis is reported as a time of suffering, with a potential for transformation, covering subjective, social, and family aspects. Effective crisis care involves verbal management, bonding, and teamwork. The expectations following the care of a person in crisis are aimed at the well-being, reduction of suffering, and protection of the user. **Conclusion:** It is essential to break away from the biological model in the approach to users, overcoming stigmas and strengthening comprehensive care.

KEYWORDS: Mental Health Services; Crisis Intervention; Drug Users; Patient Care Team; Qualitative Research.

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INTRODUCTION

According to the philosophical dictionary, the word crisis comes from the Greek "krisis", which means "choice, selection, and decision"[1]. In the context of mental health, the crisis is related to the events experienced by the individual in their daily life and how the subject reacts to them, which can affect their routine and the coexistence in society of those in acute psychological distress, as well as the people they live with[2]. It is not necessarily brief and is not overcome exclusively by eliminating the symptoms. However, it is a time when the subject can express what is causing them suffering and discover ways of understanding and overcoming this anguish[2-4].

From the perspective of caring for people in crisis who use alcohol and other drugs, crises can be related to intoxication due to substance use, withdrawal, psychiatric and clinical comorbidities, and interpersonal relationship difficulties[5].

The biomedical model, centered on the disease, classifies the crisis based on identifying acute psychiatric conditions and evaluating their intensity, frequency, and severity of symptoms to build a historical equivalence between severity, dangerousness, and psychiatric hospitalization[4]. In this way, the crisis is configured solely as a psychiatric emergency, defining the institutional space for care and generating a strong tendency to erase social, cultural, and existential issues, in other words, reducing the subject to psychic imbalance[3].

The paradigmatic shift initiated by Law 10.2016/2001, known as the Psychiatric Reform Law[6-7], makes the commitment of the Psychosocial Care Centers (CAPS) in dealing with crises essential to strengthening the psychosocial care model, built through care in freedom, with respect for human rights and subjectivities.

The Alcohol and Drug Psychosocial Care Center (CAPSad III) is a modality that provides 24-hour care and between eight and 12 reception and observation beds in municipalities with more than 150,000 inhabitants for people who use alcohol and other drugs[8]. It is one of the Psychosocial Care Network (RAPS) services responsible for caring for people in crises, focusing beyond the psychiatric symptoms, aiming for comprehensive care, and guaranteeing users' rights[6-9].

The purpose of this article is to strengthen the understanding of care for people in crisis at CAPSad III to understand the crisis as a singular and disruptive experience, which produces painful experiences marked by uncertainty, fear, and strangeness; however, it contains creative elements, which express the particularities of the subject and the manifestation of desire[4]. It also aims to break with coercive practices and include social, political, and economic factors in discussions, which define the rights of people in psychological distress[10].

To better understand this issue, we are relying on a qualitative study using Alfred Schutz's phenomenological framework, focusing on the theory of social action, which defines that a motivated behavior carries out every action, categorizing these motivations into two groups: "reasons for" and "reasons why". The "reasons for" are the motivations related to the future to define why a certain action was carried out, and the "reasons why" refer to past experiences, which are responsible for how the subject acted[11].

Therefore, the general objective of this study is to understand the meaning of the crisis phenomenon and the motivations and expectations of workers in crisis care at a Psychosocial Care Center for Alcohol and Drugs (CAPSad).

METHOD

This is a qualitative study based on the social phenomenology of Alfred Schutz, the result of a master's thesis in Nursing at the Universidade Federal do Rio Grande do Sul.

The study setting was a CAPSad III in Porto Alegre, Rio Grande do Sul, Brazil. The participants were CAPSad III workers. The inclusion criteria were CAPSad III workers who experience crises in their daily work and have at least three months of experience working in CAPSad III. The exclusion criteria were workers on vacation or maternity and health leave. There were no refusals, and the exclusion criteria were not met.

The Snowball strategy was used to collect information. The seeds in the sample were selected through an invitation to the collective after the research had been presented at the team meeting of the service being researched.

There were 13 health workers (three nurses, two occupational therapists, two psychologists, two psychiatrists, one physical education professional, one social worker, and two nursing technicians) and one administrative assistant, totaling 14 workers interviewed. Of these, 11 were interviewed virtually using the Google Meet videoconferencing platform, recorded on audio and video. Only three interviews were conducted in person at CAPSad III and audio-recorded. The choice to conduct the interviews via a videoconferencing platform was due to the COVID-19 pandemic, which was still in force when the information was collected for this study.

The information was collected between January and February 2022. In the phenomenological interview, the following guiding questions were used to understand the phenomenon's essence: What do you mean by crisis? Tell me what you have in mind when caring for people in crisis at CAPSad III? What are your expectations of the user after the crisis?

The interviews lasted 7.4 hours, with an average recording time of 31 minutes for each interview. The interviews and perceptions were transcribed by the researcher using Microsoft Office 2022, with the prior authorization of the participants. The results were subjected to the phenomenological analysis of Alfred Schutz's social phenomenology, consisting of the following stages: 1) Initial reading of the transcribed speeches in search of the meaning of the workers' actions; 2) Identify the passages that present the meaning of the workers' actions in the face of the crisis phenomenon; 3) Search for convergences of the units of meaning using phenomenological analysis, to gather the significant information found in the speeches, to construct the concrete categories corresponding to the workers' actions in the face of the crisis at CAPSad[13].

The workers were identified with the letter E for interview, followed by the number referring to the order in which they were interviewed. The interpretation of the results was analyzed using the theoretical conceptions of the phenomenological sociology of Alfred Schütz and scholars of the subject under study.

Because this research collected information virtually for those who chose to do so, the rights of the interviewees were guaranteed, as set out in Circular Letter No. 1/2021-CONEP/SECNS/MS of March 3, 2021, regarding ethical procedures in research in the virtual environment.

The Informed Consent Form (ICF) for those who took part in the interview virtually was sent to each participant's e-mail address, digitally signed, and sent to the researcher. For those who opted for a face-to-face interview, the ICF was given in two copies, one with the researcher and the other with the interviewee.

The study was approved by the Ethics and Research Committee (ERC) of the Universidade Federal do Rio Grande do Sul and by Hospital Mãe de Deus/Associação Educadora São Carlos via Plataforma Brasil, and was approved on December 9, 2021, by Consubstantiated Opinion number 3.578.583.

RESULTS

Fourteen workers took part in the survey, eight of whom were male. Their ages ranged from 21 to 40. As for professional training, nine participants (64.28%) have a *latu sensu* specialization. The time the professionals have been working in the service ranged from 11 months to eight years; however, the majority of those interviewed, around eight participants, have been working in the service for between one and three years. As for training in mental health, nine participants (64.28%) had training in this area.

By analyzing, understanding, and interpreting the information within the framework of social phenomenology, it was divided into three concrete categories: understanding and the main causes of the crisis phenomenon; the motivations behind the workers' actions in the face of the crisis phenomenon; and the workers' expectations when caring for people in crisis.

The workers identify the situation of the person in crisis as a vital moment for the construction of the subject in the world of life, which is crossed by complex situations that emerge from psychic alterations, which are not only negative but an act of subjective transformation, of self-knowledge and as a power for something to be built and modified:

When we have an imbalance, that's when we produce new knowledge. So, the idea of crisis is to disorganize, mess things up, get things out of place, and then be able to produce another response with it. (E02)

The crisis may be milder or more complex, but in a way that is not necessarily negative, it can be a positive aspect that makes you change. (E03)

I understand the crisis as part of a vital process. (E06)

The workers also stress that a crisis can be an acute moment requiring immediate care and rapid intervention to minimize possible harm to the user, thus helping to reduce psychological suffering. The following are defined as acute crises by the interviewees: attempted suicide, intoxication by alcohol and other drugs, and psychomotor agitation with a risk of self-harm and hetero-harm:

These bouts of psychomotor agitation, aggression, and irritation when they come in hostile or abusive when they're intoxicated. (E08)

When you say the word crisis in Mental Health, it reminds me of a patient at risk of aggression, doesn't it? Patient at risk of suicide. (E11)

You have to be very clever, you have to be very quick, and you can't wait! (E12)

The main causes listed by the workers as to why crises develop include aspects that go beyond the person in crisis but also take into account the social and cultural environment of the users, identifying family conflicts, the lack of a support network, and socio-economic issues as the main causes:

The crisis began to worsen (referring to the user), *and he began to break ties with his wife, and it became very acute.* (E04)

A patient tried to commit suicide in front of us. Her husband abandoned her; her children abandoned her. (E13)

How difficult it is for families to deal with the user, who is sometimes the scapegoat for the family crisis, the big symptom, and the family is all disorganized. (E08)

Various factors cause this crisis to begin, such as not having enough money, not having enough to eat at home, and having left your job. (E05)

The COVID-19 pandemic was listed by the participants in this study as something that affected society as a whole, generating health-related problems combined with social and economic issues to varying degrees:

There was a pandemic and a crisis; we broke a world paradigm, and people were affected by this change. (E08)

During the pandemic, the family lost their jobs. That person who used to be the head of the family is no longer working and has relapsed: they used the severance money on substances. (E05)

From the workers ' reports, it is possible to identify workers' value in not reproducing practices that violate their rights, such as unnecessary mechanical restraints. To prevent this from happening, they stress the importance of cohesion and trust between team members:

When you need mechanical containment, the crisis mobilizes me much more because it gives me the feeling that you need to trust your colleagues and your team to do it right so that it isn't violent and punitive. (E01)

I think it's a difficult time for everyone (referring to mechanical restraint), *both for the people who come to us and for us.* (E06)

That's when you need a lot of teamwork. (E08)

The team has to be in tune with each other to manage this situation without hurting anyone. (E11)

It is clear from the workers' speeches that the main action in moments of psychic crisis, related to psychomotor agitation and the risk of self-injury and hetero-injury, is listening and verbal management in an attempt to sensitize the person to trust the team, even if the workers have to stay for long periods in crisis care:

But I ended up handling him [referring to the user]. *Sometimes five times a week, every day at eight o'clock in the morning, the user would go there to be contained in this sense of affection.* (E02)

Yes. Sometimes, you'll have to handle the user fifty times. (E03)

Oh, man! Stay calm! We'll help you. I'm here. Got it? No one is judging you. (E13)

It's not a crisis that you have to go there and medicate and contain, but sometimes a listening ear. (E12)

The worker's bond with the user proved to be a fundamental tool in handling crises, exercising a relationship of trust and understanding:

I remember a user I followed for a while who had a very artistic streak, and he had links with specific people. At a time of crisis when he was psychotic, with ideas of suicidal ideation and a very serious risk of suicide, the people most closely associated with him on the team had to take him to a space where he could see the sky and sing a specific song. That was something that reassured him. (E01)

I think the bond is essential at a time of crisis. For example, when a user arrives in crisis, always look for a reference technician, someone they already trust, someone they already have a bond with, so that person can try to stabilize them in their speech and verbal handling. (E09)

The workers' main expectations after caring for the person in crisis are related to the user's well-being and reduced suffering:

So the idea of the services, regardless of the type of crisis, is for the person to have a break from that suffering or not to have a greater risk of suicide, of relationships, of being exposed to moral issues. (E04)

I hope to reduce the suffering the person is going through. (E06)

May it get better! Always! That the suffering is minimized, that they can cope with that suffering, or that something in the form of any tool, such as a conversation, medication, a hug, a welcome, whatever it may be, can alleviate that suffering. (E14)

It is considered a therapeutic success when the workers can provide care based on verbal management and listening to the user, with a high expectation that there will be no need for protective mechanical restraint:

One of the greatest tensions is that we don't have to restrain this person physically. Effective verbal and chemical management. (E01)

The person can reflect, return to tranquillity, and not need to be restrained. (E11)

And I always hope to steer the situation towards something more friendly without being restrained. (E13)

The workers want to find the best way of dealing with crises without the user suffering any serious physical, family, or social compromises:

We always protect the user from exposure so they can't risk themselves. (E03)

I always hope the person doesn't suffer physical, relationship, or network damage. (E04)

Try to take as little risk as possible and not make a loss. (E07)

But I always hope that nobody gets hurt. (E11)

DISCUSSION

Understanding the crisis phenomenon includes aspects of the workers' experience based on motivated behaviors, which are part of their subjective experience in life[11]. This understanding has been broadened and used beyond a so-called psychotic experience, but as a process of transformation, of overcoming conflicting moments, an event that is part of a vital process, a reframing worldly experience[14].

Despite the broadening of what is understood as a crisis, the subject is complex and goes through different conceptions, sometimes antagonistic to each other, which may be more in line with traditional psychiatry under the influence of the biological model – focused exclusively on the worsening of symptoms and the ways of intervening to reduce them – or according to psychosocial thinking, which encompasses the concept of crisis beyond an acute moment that needs to be "fought", but as a moment of imbalance, subjective and full of meanings, which encompasses both subject and society[3-4].

Workers operate according to their "stock of knowledge." In other words, what they have experienced throughout their lives in the social world is built based on their personal, academic, and professional experiences, with family and social influences. Workers often have experiences linked to the biomedical model, centered on fragmented principles, and it is a challenge in the daily life of CAPS to break away from this *modus operandi*[11-15].

It is possible to observe that this disease-centered model is still very present in undergraduate health courses, culminating in the training of workers whose actions do not understand the integrality of the user[14-16].

To overcome the biological model and the asylum model of care, based on social exclusion and psychiatric symptoms, one of the main tools is permanent education to group the field of mental health within the scope of collective health, in which it is possible to understand the health-disease process as a consequence of multifactorial and complex social processes, which demand an interdisciplinary, transdisciplinary and intersectoral approach, building a network of territorialized services to promote attention and care[17].

The user's institutional and emotional networks, as well as their experiences in the world of life, are important bridges for the construction of a Singular Therapeutic Plan (STP), which is carried out by the worker together with the user and aims to draw up care strategies with short, medium and long-term goals, to enhance the individual's quality of life. In this way, observing the individual beyond their pathology or crisis is possible, looking for aspects of their subjective experience and the social and family context, as these factors are fundamental in mental health care. Without them, it is essential to build new possible paths[18].

In the context of people who use alcohol and other drugs, it has been observed that family abandonment, low social support, experience of life on the streets, a history of trauma, and exposure to drugs within the family nucleus are factors that contribute to the problematic use of psychoactive substances[19-20]. The family is an important part of caring for people in crisis, and workers need to build tools to equip family members to deal with these situations, creating a close relationship with the health service in a welcoming and non-punitive way[21]. Family groups and family therapy have proven to be important care strategies for the caregiver, creating spaces for sharing, producing an exchange of knowledge between peers, and promoting a reduction in the burden[19,21].

The COVID-19 pandemic was evidenced in this study as a factor that contributed to the increase in crises in people who use alcohol and other drugs beyond the biological aspect, as well as aggravating social and economic issues, affecting the population in different proportions. The period of social isolation that the population had to endure to control the spread of the COVID-19 virus was one of the causes of the worsening of pre-existing factors, such as increased alcohol use, relapses in substance use, and the development of other more serious problems related to alcohol use[22].

To manage severe crises, workers identify chemical and mechanical containment techniques. These practices reduce the user's suffering and may also be related to reducing the anguish of the health worker, who has various feelings in contact with the other, which are not always easy to tolerate. In this way, stopping the user's symptom becomes the solution[14].

Before physical restrictions, health workers should focus on less invasive strategies and techniques, prioritizing verbal management to understand and welcome the user's crisis process experienced by the user[23]. Attention should also be paid to the environmental factor, removing the user from a space potentially potentiating their suffering[24]. However, there are many perceived obstacles to workers embracing new technologies in the care of people in crisis, which is closely linked to the subjective nature of the action, which generates greater complexity in care[24].

It is not an institutional protocol that will ensure team cohesion, but rather the relationship built between managers/workers/users, which must be by the precepts of the psychosocial care model, beyond pre-established medical parameters[24].

When care for the person in crisis is centered on the symptom, to resolve it quickly, with involuntary practices, be they chemical or mechanical restraints, sometimes even by police action, there is no room for understanding the phenomenon through the eyes of the subjects involved, because the actions are based on the aim of silencing and "resolving" the situation[3-6].

For a therapeutic relationship to form between worker and user at the moment of crisis, one must be aware of the other's existence, in a reciprocal way, in a face-to-face relationship in which both share a common time and space[25].

The face-to-face relationship is the first step in building a precise and lasting bond between worker and user. Therefore, it is necessary to recognize the user as a subject with a history and experience and not merely as an object of intervention[3,6].

Bonding and listening are considered new relationships and perspectives in mental health care, and without them, the relationship that the subject establishes with the drug is not capable of changing. One factor facilitating the link is open-door services, which represent a social and health commitment between services and people. In this way, it is possible to offer easily accessible care to people in a psychic crisis, with greater resolution of their demands[26].

It is necessary to discuss more than models of action; it is necessary to discuss the ethical-political direction of the production of humanization, demystifying moralisms of how one should live from a unique and personal experience, opening the field to difference, and problematizing the current social norm. In this way, it is possible to open paths to care in freedom, accepting singularities truly[27].

The study had limitations when it came to conducting the interviews because, due to the COVID-19 pandemic, most of the interviews had to be conducted on the online platform, making it difficult for the researcher to get close to the interviewees in their entirety. It is also worth mentioning the overload of workers and the fear of contamination by the virus, which may have interfered with the interviewees' answers and their willingness to participate in the survey. In the face-to-face interviews, the use of Personal Protective Equipment (PPE) and the distance at the time of the interview made the relationship between researcher and researched more difficult.

CONCLUSION

The findings of this article point to a broader understanding of the crisis phenomenon on the part of the workers, considering not only exclusively biological aspects but also their subjectivity and the family and social context in which the user was inserted. In the aspects related to the reasons for the workers' actions when dealing with people in crisis,

the importance of the multi-professional team being cohesive in its approach to this user can be seen, as well as the importance of verbal management and building a bond.

Regarding the expectations related to the workers' objectives about the actions, it is clear that the workers are involved with a focus on well-being, promoting the reduction of the user's suffering, based on practices aligned with care in freedom and respect for human rights, to avoid indiscriminate and unnecessary containment approaches.

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